DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

April 4, 2023

THIS LETTER SENT VIA EMAIL TO: dortiz@tularecounty.ca.gov

Ms. Donna Ortiz, Director
Tulare County Health & Human Services Agency
5957 S. Mooney Blvd.
Visalia, CA 93277

SUBJECT: ANNUAL COUNTY COMPLIANCE SECTION DMC-ODS FINDINGS REPORT

Dear Director Ortiz:

The Department of Health Care Services (DHCS) is responsible for monitoring compliance to the requirements of the Drug Medi-Cal Organized Delivery System (DMC-ODS) and the terms of the Intergovernmental Agreement operated by Tulare County.

The County Compliance Section (CCS) within the Audits and Investigations Division (A&I) of DHCS conducted a review of the County's compliance with contract requirements based on responses to the monitoring instrument, discussion with county staff, and supporting documentation provided by the County. Enclosed are the results of Tulare County's Fiscal Year 2022-23 DMC-ODS compliance review. The report identifies deficiencies, required corrective actions, advisory recommendations, and referrals for technical assistance.

Tulare County is required to submit a Corrective Action Plan (CAP) addressing each compliance deficiency (CD) to the Medi-Cal Behavioral Health – Oversight and Monitoring Division (MCBH-OMD), County/Provider Operations and Monitoring Branch (CPOMB) Liaison by 6/5/2023. Please use the enclosed CAP form to submit the completed CAP and supporting documentation via the MOVEit Secure Managed File Transfer System. For instructions on how to submit to the correct MOVEit folder, email MCBHOMDMonitoring@dhcs.ca.gov.

If you have any questions, please contact me at michael.bivians@dhcs.ca.gov.

Sincerely,

Michael Bivians | Unit Chief

Distribution:

To: Director Ortiz,

CC: Mateo Hernandez, Audits and Investigations, Medical Review Branch Acting Chief
Catherine Hicks, Audits and Investigations, Behavioral Health Compliance Section Chief
Ayesha Smith, Audits and Investigations, Behavioral Health Compliance Unit Chief
Michael Bivians, Audits and Investigations, County Compliance Monitoring II Chief
Cindy Berger, Audits and Investigations, Provider Compliance Unit Chief
Sergio Lopez, County/Provider Operations Monitoring Section I Chief
Tony Nguyen, County/Provider Operations Monitoring Section II Chief
MCBHOMDMonitoring@dhcs.ca.gov, County/Provider Operations and Monitoring Branch
Gilberto Rivas, Tulare County Behavioral Health Branch Deputy Director
Chandler Bailey, Tulare County Behavioral Health Branch Quality Improvement Unit Manager

COUNTY REVIEW INFORMATION

County:
Tulare

County Contact Name/Title:
Chandler Bailey / Behavioral Health Branch Quality Improvement Unit Manager

County Address:
5957 S. Mooney Blvd.
Visalia, CA 93277

County Phone Number/Email:
(559) 303-5484
cbailey@tularecounty.ca.gov

Date of DMC-ODS Implementation:
7/1/2019

Date of Review:
2/16/2023

Lead CCM II Analyst:
Michael Bivians

Assisting CCM II Analyst:
N/A

Report Prepared by:
Michael Bivians

Report Approved by:
Ayesha Smith

REVIEW SCOPE

I. Regulations:
   a. Special Terms and Conditions (STCs) for California Advancing & Innovating Medi-Cal (CalAIM) 1915(b) Waiver
   b. Code of Federal Regulations, Title 42, Chapter IV, Subchapter C, Part 438; section 438.1 through 438.930: Managed Care
   c. California Code of Regulations, Title 9, Division 4: Department of Drug and Alcohol Programs
   d. California Health and Safety Code, Chapter 3 of Part 1, Division 10.5: Alcohol and Drug Programs
   e. California Welfare and Institutions Code, Division 9, Part 3, Chapter 7, sections 14000 et seq., in particular but not limited to sections 14100.2, 14021, 14021.5, 14021.6, 14021.51-14021.53, 14124.20-14124.25, 14043, et seq., 14184.100 et seq. and 14045.10 et seq.: Basic Health Care

II. Program Requirements:
   a. Fiscal Year (FY) 2021-22 Intergovernmental Agreement (IA)
   b. Fiscal Year (FY) 2022-23 Intergovernmental Agreement (IA)
   c. Mental Health and Substance Use Disorders Services (MHSUDS) Information Notices
   d. Behavioral Health Information Notices (BHIN)

ENTRANCE AND EXIT CONFERENCE SUMMARIES

Entrance Conference:

An Entrance Conference was conducted via WebEx on 2/16/2023. The following individuals were present:

- Representing DHCS:
  Michael Bivians, County Compliance Monitoring II (CCM II) Chief
  Natalia Krasnodemsky, County/Provider Operations and Monitoring (CPOM) Liaison

- Representing Tulare County:
  Gilbert Rivas, Tulare County Behavioral Health Branch Deputy Director Administrative Services
  Chandler Bailey, Tulare County Behavioral Health Branch Quality Improvement-SUD Unit Manager
  Omar De Leon, Tulare County Behavioral Health Prevention Services Coordinator
  Larry Fishburn, Tulare County Behavioral Health County Mental Health Case Manager
  Sandy Lucas, Tulare County Behavioral Health County Alcohol & Drug Specialist
  Michelle Trigleth, Tulare County Behavioral Health Clinician

During the Entrance Conference, the following topics were discussed:

- Introductions
- Overview of review process
- County overview of services provided

Exit Conference:

An Exit Conference was conducted via WebEx on 2/16/2023. The following individuals were present:

- Representing DHCS:
  Michael Bivians, CCM II Chief
  Natalia Krasnodemsky, CPOM Liaison

- Representing Tulare County:
  Gilbert Rivas, Tulare County Behavioral Health Branch Deputy Director Administrative Services
  Chandler Bailey, Tulare County Behavioral Health Branch Quality Improvement-SUD Unit Manager
  Omar De Leon, Tulare County Behavioral Health Prevention Services Coordinator
  Larry Fishburn, Tulare County Behavioral Health County Mental Health Case Manager
  Sandy Lucas, Tulare County Behavioral Health County Alcohol & Drug Specialist
  Michelle Trigleth, Tulare County Behavioral Health Clinician

During the Exit Conference, the following topics were discussed:

- Submitting follow-up evidence
- Due date for evidence submission

SUMMARY OF FY 2022-23 COMPLIANCE DEFICIENCIES (CD)

	Section:	Number of CDs
1.0	Availability of DMC-ODS Services	7
2.0	Coordination of Care Requirements	0
3.0	Quality Assurance and Performance Improvement	0
4.0	Access and Information Requirements	2
5.0	Beneficiary Rights and Protections	2
6.0	Program Integrity	1

CORRECTIVE ACTION PLAN (CAP)

Pursuant to the Intergovernmental Agreement, Exhibit A, Attachment I, Part III, Section QQ each CD identified must be addressed via a CAP. The CAP is due within sixty (60) calendar days of the date of this monitoring report.

Please provide the following within the completed FY 2022-23 CAP:

a) A list of action steps to be taken to correct the CD.
b) The name of the person who will be responsible for corrections and ongoing compliance.
c) Provide a specific description on how ongoing compliance is ensured.
d) A date of completion for each CD.

The CPOMB liaison will monitor progress of the CAP completion.

Category 1: AVAILABILITY OF DMC-ODS SERVICES

A review of the administrative trainings, policies and procedures was conducted to ensure compliance with applicable regulations, and standards. The following deficiencies in availability of DMC-ODS services were identified:

COMPLIANCE DEFICIENCIES:

CD 1.2.1:
Intergovernmental Agreement Exhibit A, Attachment I, II, H, 6, i-v

i. The Contractor and its subcontractors shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:
   a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
   b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.

ii. The Contractor and its subcontractors shall not have a relationship with an individual or entity that is excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Act.

iii. The relationships described in paragraph (i) of this section, are as follows:
   a. A director, officer, or partner of the Contractor.
   b. A subcontractor of the Contractor, as governed by 42 CFR §438.230.
   c. A person with beneficial ownership of five percent or more of the Contractor's equity.
   d. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement.

iv. If the Department finds that the Contractor is not in compliance, the Department:
   a. Shall notify the Secretary of the noncompliance.
   b. May continue an existing Agreement with the Contractor unless the Secretary directs otherwise.
   c. May not renew or otherwise extend the duration of an existing Agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliations.
   d. Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

v. The Contractor shall provide the Department with written disclosure of any prohibited affiliation under this section by the Contractor or any of its subcontractors.

Findings: The Plan did not provide evidence to demonstrate compliance with the practice of identifying Plan and subcontracted network providers knowingly having prohibited relationships with:

- An individual or entity debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual or entity defined as an affiliate of an individual or entity debarred, suspended, or excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
- An individual or entity excluded from participation in Federal Health Care Program under section 1128 or 1128A of the Act.

CD 1.2.2:

Intergovernmental Agreement Exhibit A, Attachment I, III, J, 3

3. The Contractor shall only select providers that have a Medical Director who, prior to the delivery of services under this Agreement, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this Agreement, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

Findings: The Plan did not provide evidence to demonstrate Plan and subcontracted network providers only select providers that have a Medical Director who:

- Enrolled with DHCS under applicable state regulations.
- Screened as a “limited” categorical risk within a year prior to serving as a Medical Director.
- Signed a Medicaid provider agreement with DHCS.

CD 1.2.3:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5, i, a, i-ii

i. The Contractor shall implement written policies and procedures for selection and retention of network providers and the implemented policies and procedures, at a minimum, meet the following requirements:
   a. Credentialing and re-credentialing requirements.
      i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
      ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.

MHSUDS Information Notice: 18-019

CREDENTIALING POLICY 2018

For all licensed, waivered, registered and/or certified providers4, the Plan must verify and document the following items through a primary source, 5 as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the Plan unless the Plan can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board.

1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition, Plans must verify and document the following information from each network provider, as applicable, but need not verify this information through a primary source:

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/;
9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and

Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp; and

10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

Provider Re-credentialing
DHCS requires each Plan to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above.

42 CFR §438.214

Findings: The Plan provided evidence to demonstrate implemented policies and procedures for the selection and retention of network providers however; did not provide evidence to demonstrate the practice of staff verifications using excluded database checks.

CD 1.2.4:

Intergovernmental Agreement Exhibit A, Attachment I, II, E, 5, i, a, i-ii

i. The Contractor shall implement written policies and procedures for selection and retention of network providers and the implemented policies and procedures, at a minimum, meet the following requirements:
   a. Credentialing and re-credentialing requirements.
      i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
      ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers

MHSUDS Information Notice: 18-019

Attestation

For all network providers who deliver covered services, each provider's application to contract with the Plan must include a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
2. A history of loss of license or felony conviction;
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness.

42 CFR §438.214

Findings: The Plan did not provide evidence to demonstrate all network providers who deliver covered services sign and date a written attestation regarding their credentials.

CD 1.3.1:

Intergovernmental Agreement Exhibit A, Attachment I, III, B, 1, v

v. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.

Findings: The Plan did not provide evidence to demonstrate physicians from two subcontracted Network Providers received the annual five (5) hours of continuing medical education (CME) in addiction medicine.

CD 1.3.2:

Intergovernmental Agreement Exhibit A, Attachment I, III, B, 1, vi

vi. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.

Findings: The Plan did not provide evidence to demonstrate subcontractor non-physician professional staff (LPHA) received the annual five (5) hours of continuing education units (CEU) in addiction medicine.

CD 1.3.4:

Intergovernmental Agreement Exhibit A, Attachment I, III, MM, 3, ii, c

c. The Contractor shall ensure that all personnel who provide WM services or who monitor or supervise the provision of such service shall meet additional training requirements set forth in BHIN 21-001 and its accompanying exhibits.

BHIN 21-001

Findings: The Plan did not provide evidence to demonstrate all personnel who provide Withdrawal Management (WM) services or who monitor or supervise the provision of such service meet the required training set forth in BHIN 21-001, specifically;

- Certified in cardiopulmonary resuscitation;
- Certified in first aid;
- Trained in the use of Naloxone;
- Six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of WM services;
- Repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment;
- Eight (8) hours of training annually that covers the needs of residents who receive WM services;
- Training documentation must be maintained in personnel records; and
- Personnel training shall be implemented and maintained by the licensee pursuant to CCR, Title 9, Section 10564(k).

Category 4: ACCESS AND INFORMATION REQUIREMENTS

A review of the access and information requirements for the access line, language and format requirements, and general information was conducted to ensure compliance with applicable regulations and standards. The following deficiencies in access and information requirements were identified:

COMPLIANCE DEFICIENCIES:

CD 4.3.2:
Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 15, i-xiii
15. Federal Law Requirements:
   i. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
   ii. Title IX of the Education Amendments of 1972 (regarding education and programs and activities), if applicable.
   iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
   iv. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
   v. Age Discrimination in Employment Act (29 CFR Part 1625).
   vi. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
   vii. Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
   viii. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
   ix. Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
   x. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
   xi. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
   xii. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
   xiii. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

Intergovernmental Agreement Exhibit A, Attachment, III, CC, 18, i
18. Subcontract Provisions
   i. Contractor shall include all of the foregoing provisions in all of its subcontracts.

Findings: The Plan did not provide evidence to demonstrate all Federal Law Requirements from the Intergovernmental Agreement, Exhibit A, Attachment I, III, CC, 15, i-xiii, foregoing provision is included in all subcontracts, specifically:

- Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.).
- Age Discrimination in Employment Act (29 CFR Part 1625).
- Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60).
- Executive Order 13166 (67 FR 41455).
- The Drug Abuse Office and Treatment Act of 1972.
- The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616).

CD 4.3.3:

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 16, i-v

16. State Law Requirements:
    i. Fair Employment and Housing Act (Gov. Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (Cal. Code Regs., tit. 2, Div. 4 § 7285.0 et seq.).
    ii. Title 2, Division 3, Article 9.5 of the Gov. Code, commencing with Section 11135.
    iii. Cal. Code Regs., tit. 9, div. 4, chapter 8, commencing with §10800.
    iv. No state or Federal funds shall be used by the Contractor, or its subcontractors, for sectarian worship, instruction, and/or proselytization. No state funds shall be used by the Contractor, or its subcontractors, to provide direct, immediate, or substantial support to any religious activity.
    v. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

Intergovernmental Agreement Exhibit A, Attachment I, III, CC, 18, i

18. Subcontract Provisions
    i. Contractor shall include all of the foregoing provisions in all of its subcontracts.

Findings: The Plan did not provide evidence to demonstrate all State Law Requirements from the Intergovernmental Agreement, Exhibit A, Attachment I, III, CC, 16, i-v, foregoing provision is included in all subcontracts, specifically:

- Fair Employment and Housing Act.
- Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
- No state or Federal funds are used by the Contractor, or its subcontractors, for sectarian worship, instruction, and/or proselytization. No state funds are used by the Contractor, or its subcontractors, to provide direct, immediate, or substantial support to any religious activity.

Category 5: BENEFICIARY RIGHTS AND PROTECTIONS

A review of the grievance and appeals was conducted to ensure compliance with applicable regulations and standards. The following deficiency in beneficiary rights and protections for regulations, standards, or protocol requirements was identified:

COMPLIANCE DEFICIENCY:

CD 5.2.1:
Intergovernmental Agreement Exhibit A, Attachment I, II, L, 1-3, i-iii

1. The Contractor shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.
2. The Contractor shall adopt Discrimination Grievance procedures that ensure the prompt and equitable resolution of discrimination-related complaints. The Contractor shall not require a beneficiary to file a Discrimination Grievance with the Contractor before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.
3. The Discrimination Grievance Coordinator shall be available to:
    i. Answer questions and provide appropriate assistance to the Contractor staff and members regarding the Contractor's state and federal nondiscrimination legal obligations.
    ii. Advise the Contractor about nondiscrimination best practices and accommodating persons with disabilities.
    iii. Investigate and process any Americans with Disabilities Act, Section 504 of the Rehabilitation Act, section 1557 of the Affordable Care Act, and/or Gov. Code section 11135 grievances received by the Contractor.

Findings: The Plan did not provide evidence to demonstrate the investigation of grievances related to any action prohibited by or out of compliance with federal or state nondiscrimination law based on the following characteristics, specifically:

- Genetic Information
- Marital Status

CD 5.2.2:

Intergovernmental Agreement Exhibit A, Attachment I, II, L, 4, j, a-f

4. The Contractor shall comply with the following discrimination grievances reporting requirements.
    i. Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the Contractor shall submit detailed information regarding the grievance to DHCS Office of Civil Rights' designated Discrimination Grievance email box. The Contractor shall submit the following detailed information in a secure format to DHCS.DiscriminationGrievances@dhcs.ca.gov:
        a. The original complaint.
        b. The provider's or other accused party's response to the grievance.
        c. Contact information for the Contractor's personnel responsible for the Contractor's investigation and response to the grievance.
        d. Contact information for the beneficiary filing the grievance and for the provider or other accused party that is the subject of the grievance.
        e. All correspondence with the beneficiary regarding the grievance, including, but not limited to, the Discrimination Grievance acknowledgment and resolution letter(s) sent to the beneficiary.
        f. The results of the Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

Findings: The Plan did not provide evidence of procedures demonstrating compliance with reporting requirements regarding Discrimination Grievance, specifically:

- Discrimination Grievance information is submitted to the DHCS Office of Civil Rights within ten (10) calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary.
- Discrimination Grievance information is submitted to the DHCS Office of Civil Rights in a secure format to DHCS.DiscriminationGrievances@dhcs.ca.gov.
- The original complaint.
- The provider's or other accused party's response to the grievance.
- Contact information for the Contractor's personnel responsible for investigating and responding to the complaint.
- Contact information for the beneficiary filing the complaint.
- Contact information for the provider or other accused party that is the subject of the complaint.
- All correspondence with the beneficiary regarding the compliant, including, but not limited to, the Discrimination Grievance acknowledgement and resolution letter(s) sent to the beneficiary.
- Results of the Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

Category 6: PROGRAM INTEGRITY

A review of the compliance program, service verification, and fraud reporting was conducted to ensure compliance with applicable regulations and standards. The following deficiency in program integrity was identified:

COMPLIANCE DEFICIENCY:

CD 6.2.1:
Intergovernmental Agreement Exhibit A, Attachment III, NN, 3

3. Suspected Medi-Cal fraud, waste, or abuse shall be reported to: DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov.

Findings: The Plan did not provide evidence to demonstrate Plan and subcontractor compliance with reporting suspected Medi-Cal fraud, waste, or abuse to DHCS Medi-Cal Fraud at (800) 822-6222 or Fraud@dhcs.ca.gov.

TECHNICAL ASSISTANCE

Tulare County did not request Technical Assistance during this review.